Aboriginal and Torres Strait Islander Health Practice Board of Australia | AHPRA

Transcript –

A forum on registration for Aboriginal and Torres Strait Islander health practitioners

26 February 2014

Bruce Davis: Alright, I'd just like to welcome everyone to this forum on Aboriginal and Torres Strait Islander Health Practitioner Registration. My name's Bruce Davis and I'm the practitioner member for Queensland at the moment. I'm working in Cairns with Wuchopperen Health Service. I'm the team leader for the health practitioners there. I've been a health worker for going on 19 years registered for most of that and did a lot of work up in the Northern Territory.

First of all we'd like to thank our partners in this, Queensland Health, the Queensland Aboriginal and Islander Health Council (QAIHC) and Australian Medicare Local Alliance and to get things started I might just get Aunty Valda Coolwell to come up and do an acknowledgement. Thank you.

Valda Coolwell: Thank you Bruce. We are walking, we are talking, we are gathering on Aboriginal country, so we need to acknowledge the traditional owners of this space here today. So I give honour and respect and acknowledge the Turrbal peoples of the north of the Brisbane River and likewise I give honour and respect and acknowledge the Jagara, the Ugarapul people, the Munanjahalli people, Nunukul, Ngugi, Undanbi people who are on the borders of this very special area.

I give praise and honour to my god and creator. In my language we called him Birrabi[1] who placed us in this country as caretakers and custodians of the land.

We never forget our ancestors who walked this land before us, for we believe their spirits are still with us. They're in the mountains, the rivers, the rocks, the trees, the animals, everywhere.

We acknowledge our elders and give them our respect for they hold the knowledge of culture, of law, of language, story, song and corroboree, passing it down to the young ones and for future generations for all to share.

We never forget those men and women both black and white, young and old, who took to the streets to highlight the many injustices and disadvantage that we as Aboriginal and Torres Strait Islander people have had to endure, but also for the strength it gives us to take hold of those many opportunities afforded us because of their passion to a cause.

I always like to acknowledge the man who said sorry to the Stolen Generations and the lead up to that through those other people but they never said it, but anyhow we acknowledge Kevin Rudd for saying sorry and giving us pride in who we are and where we come from. It brought a tear to everyone's eye that special day and of course the promise of governments to close the gap in health of which you all are part

[1] Goorang Goorang language.

of, education, employment and housing, thereby making my people, your people, strong and proud of who they are and where they come from.

But today I'm here to acknowledge the health practitioners of who you are and what you do to help our mob in the search for better health, better living standards and thank you for inviting me to present acknowledgement to the traditional owners of Brisbane. Verawyani unaniowhi[2]. In my language it simply means I am going. Thank you very much. Have a wonderful day working together, networking and making good decisions for our mob. Thank you.

[Applause]

Bruce Davis: Thank you Aunty Valda. I'd now like to introduce the presenter Peter Pangquee, the Chair of the Board. Thank you.

Peter Pangquee: Thanks Bruce and thank you Aunty Valda for that acknowledgement of country. I too would like to acknowledge the Jagara and Turrbal people on whose country we're standing here today.

I would like to welcome you all here. It's great to see so many people. We did one of these in Sydney and whilst we had probably 50 to 60 there, we also did a webcast and that went out to New South Wales widely, so we're hoping that we can do the same here but not necessarily a webcast, we're videoing this session. I only just found out about it today so thanks Gilbert. This is going to be put onto our website so you'll be able to share it later on with your colleagues, so hopefully we can do it without editing it. We might have to though; I didn't have my makeup on today Gilbert [laughs].

Just a little bit about myself, I've been a health worker for over 30 years. I started off in health accidentally actually. I got asked to come and work in East Arm Hospital which is a leprosy hospital in Darwin and I was actually building houses. It was the end of February, like this time of the year now, wet, hot. Two friends rang me and said we need an orderly come health worker and cleaner. It was all thrown into one bundle. Come and work in this hospital.

So I got out there and you'd empty the bin, clean the floors, empty the spit mugs, you know, all those sorts of dandy little jobs and I got asked to train as an Aboriginal health worker. I said what do they do and I soon learned what they did. It was only a three month job. Thirty years later I never climbed back on another roof I can tell you that, not in a wet season.

My family - on my father's side I'm Marrathiyiel, that's west of Darwin, other side of the Daly River and my mother's side is Yankunytjatjara which is Coober Pedy. Both my parents from Stolen Generation; one was in a home in Darwin in Retta Dixon and my mother grew up in a mission home in Port Augusta and she got sent to Darwin as a young missionary. They talk about assimilation, well dad assimilated her to Darwin [laughs] so that's where I'm from.

My current job in the Northern Territory is the Aboriginal and Torres Strait Islander health practice adviser for the NT Department of Health and I was given the task then of chairing this board to develop national registration, but my background was also with the Northern Territory Registration Board. We've had registration in the NT for - just before it came in here nationally we had it for 27 years so we've used it and we've set a lot of things in motion, a lot of things in place and we know what works and what doesn't work so I think it's been a really good background for that.

But I'll get into it and try and share some information with you about where we're at, where we've come from and I guess we can have a discussion or questions later on if you like. I'm sure there's a few, don't make them too hard.

So I'll sort of give background of the national registration and we'll talk about that and just a question there - why be part of a regulated workforce, who should register, registrants' responsibilities? Another point there, we've come a long way, the Board and AHPRA, just about our relationship with

[2] Goorang Goorang language.

AHPRA. AHPRA is the Australian Health Practitioner Regulation Agency, a mouthful, and just more information and question and answers.

Just a little bit of background is in 2008 the government agreed to tackle Aboriginal and Torres Strait Islander people's disadvantage through six ambitious targets and two of them was related especially to our health: to half the mortality rate for our children under five within a decade by 2018 and close the life expectancy gap within generation by 2031. We all know this is closing the gap so how are we progressing? I know there's been recent reports just come out on this so I haven't changed mine yet [laughs].

But in February 2013 the Parliament received the Prime Minister's Closing Gap Report. The report showed the progress against the agreed targets compared to actual achievements for the period. While the targets were under five mortality they say is on track to be met by 2018, the life expectancy target is unlikely to be met by 2031. I think there's some realities there for all of us and I think the recent report definitely indicated that.

So in July 2011 the ACSQHC - and Gilbert you might be able to tell us about what that is [laughs].

Male: The Australian Commission for Safety and Quality in Health Care

Peter Pangquee: Oh right yep, publish the Patient's Safety and Primary Healthcare Consultation Report. The report identified Aboriginal and Torres Strait Islander patients should be an area of focus to improve patient safety in primary healthcare. Aboriginal and Torres Strait Islander patients who are identified as being at more risk of safety incidents and harm than the general population.

Whilst Aboriginal and Torres Strait Islander people who are specifically mentioned in this, there are also people from other groups like from culturally, linguistically and diverse backgrounds; living in rural and remote areas; living with a permanent injury or disability; from lower socioeconomic background and limited literacy, numeracy education; income and resources; living with multiple conditions, seeing multiple providers and under multiple medications; living with chronic conditions and highly at risk of hospitalisation.

So I suppose when you look at all of that, we look at who's the best person in the community, who has the cultural and clinical competence to provide comprehensive primary healthcare to our people, so we're talking about this profession - the Aboriginal and Torres Strait Islander health practitioner.

I describe this as new - it's not really new but it's a new name I guess you could say. We've had Aboriginal health workers in Australia for many, many years. I know just in the Northern Territory, as I said, we had registration for 27 years but prior to that we've had Aboriginal health workers practising in the early '50s and even earlier in some cases, but Aboriginal and Torres Strait Islander health practitioners who are specifically trained to undertake a clinical role in primary healthcare in a culturally competent way and be a sustainable heath workforce solution.

I think in a lot of cases this has been proved, especially in some of the work that's been done in the NT - I'll talk about NT because that's specifically what I know about - using Aboriginal health practitioners in remote communities, having them doing the primary healthcare stuff, working with families, getting out of the health centre - not just putting the bandaids on but getting out and working with families and some of that is actually shown to reduce the hospitalisation rates in places. To be able to do a lot more of that work in the community and that's been done by Aboriginal health practitioners.

Just another little quick one there - for example, when I spent six years in East Arnhem as the Aboriginal health worker manager for the Department of Health and we had a 98 per cent immunisation rate in East Arnhem which is some of the best in the country, some of the best in the world immunisation rates. If you look at some of the communities they're very isolated and cut off during the wet season, so it can be done and that's because we've had Aboriginal health - at the time Aboriginal health workers but now Aboriginal health practitioners on the ground doing some of the clinical work and the ability to use medications in those cases.

I suppose why be part of a regulated workforce? I guess that's part of it what I was just saying, but what's in it for you and me and what's in it for our people? Being a registered health practitioner gives you formal recognition as a member of a profession regulated by a national law enforced in each state and territory and it ensures you have the right training to be a safe practitioner and we're working towards that.

I'm sure there'll be questions coming up about accreditation and about the training and accrediting of RTOs and that out of this group.

So being a practitioner we know that you've got the training to do the job well. Your employer and your patients have a guarantee that only health practitioners who are suitably trained and qualified to practice in a competent and ethical manner are registered. Our people deserve the level of quality assurance. Through an - sorry through an accreditation process will assess all programs of study and training leads to this profession's registration qualification.

As you know that's a Certificate IV in Aboriginal and Torres Strait Islander primary healthcare practice is the current qualification. That has just recently undergone review and it's back out there now hopefully stronger than ever. A lot of health practitioners spent a lot of time working on that and academics and people who know the industry really well and some of those are in the room here today. This will lead to improved delivery of education and training of Aboriginal and Torres Strait Islander people in the health sector which is consistent with ATSIHWWG, that's the Aboriginal and Torres Strait Islander Health Workforce Working Group National Framework 2011-2015.

Prior to that current model now there was what everybody referred to as the yellow book and if you go back to that yellow book and have a look at some of the recommendations in there, one of them was to have an Aboriginal health worker association which is up and running now. Jenny Poelina is the chair of NATSIHWA (the National Aboriginal and Torres Strait Islander Health Workers' Association). She's with us, she's on our national board as well, and national registration was one of the other recommendations in that and that's what we've got here today.

If you look back on when this was developed, it was developed out of a recognised need for this profession and to promote this profession and out of the need to actually do the work in the communities. As I said before, the NT's registration since 1985 and have responded well to national registration.

Others have responded well. For example, New South Wales increased from two to 26 and Queensland six to 35 since 2012. So it's being embraced and I've spoken to a few people around in this room but also in New South Wales, a little bit. There's a whole lot of - there seems to be a whole lot of rush to get on now and get on with the practice qualification which is really good. I think there's like 308 current registered if I remember the figures which is pretty good. I mean we're getting there.

Some of the Board key functions are to develop registration standards and guidelines for ministerial council approval. So every guideline and standard that we develop has to go out for public consultation. It goes out there for about six weeks, then it comes back and all the comments made by the public and by you guys out there come back and we adjust the standard and qualification - sorry the standard and guideline. Then it goes to Ministerial Council for approval. So it's not just something we make up and, you know, oh that'll do. It does go to consultation nationally.

We also then register suitably qualified and competent health workers in the profession, if necessary to impose conditions on registration. There are some conditions out there at the moment and you'll find that in the Act, I think it's section 303, there's a section in there on grandparenting. So if someone's been working as an Aboriginal health worker doing some clinical work over the last 10 years and they've been doing that five years in the last 10 years, they can actually apply for registration and if they can demonstrate they've got the experience, the knowledge and the actual practical work on the ground, then they can be registered. Sometimes they might be registered with a condition that they undertake some further training or something like that in a specific clinical area, but there is opportunity for some of those health workers around.

Approve accreditation standards, so since we've been operating we've actually set up an accreditation committee. The committee operates separately to the Board. Even though we set it up, we've appointed those people. They actually now run the accreditation process and some of those people are here today with us - well most them are. I'm not sure if I want to introduce just yet but maybe we can as we go.

So approved accreditation standards and processes and approved accreditation study are programs of study. Sorry just with the accreditation standard too, that all goes out for public consultation and that has been out there and it's come back in and that's now up on the website I believe, those standards. I believe that they're currently working through the guidance documents for that and application

form so they should be actually just about ready to go. I'm not sure of the exact timeframe but it's not very far away.

The development approved the profession's own code of conduct and guidelines. It's quite an extensive code of conduct for practitioners and the guidelines.

Just an example, you know, going back on those ministerial approval and guidelines and stuff, one of them you'll find in there is, they call it the Aboriginal and Torres Strait Islander guidelines and what that is you have to be an Aboriginal and Torres Strait Islander person to be a registered practitioner in this category. We thought we'd have a lot of trouble there with governments and other people saying well that's discriminatory you can't do that, but it actually was embraced and was probably one of the ones we had least comments about. I think it's great for this profession. It recognised the profession and it puts it right up there and one of the main reasons why we have this profession is we need Aboriginal and Torres Strait Islander people looking after Aboriginal and Torres Strait Islander people.

Eligibility to register - according to the Board's registration standards eligibility for registrations is [as follows], and as I just said, identify and accepted as an Aboriginal and Torres Strait Islander person. This is no different really to when people go and apply for ABSTUDY and all those other things, it's almost the same way of demonstrating that you are an Aboriginal and Torres Strait Islander person.

You must hold the HLT40213 Certificate IV in Aboriginal and Torres Strait Islander primary healthcare practice or equivalent and when we say that equivalent, that's where it comes into that grandparenting clause where someone might have had a qualification previously. There might be others from say the Northern Territory who have done some others and haven't been registered for a while. They can also then come back into the workplace. So we do look at the equivalents and we urge people to actually apply, put their equivalents in there and we have assessors that actually assess that qualification to see where it fits and then the Board makes a decision.

Not to have a serious criminal offence - a bit hard to say this but we know that there are a lot of people out there with criminal history but we take into account how long ago it was, what the offences were, the circumstances around it all. So if you've got a criminal history you're better off applying and letting the Board decide and it is a Board decision. It's not a committee sitting somewhere deciding whether your criminal history's going to stop you from being registered. We want people to apply and the Board will have a look at it. As I say, it's based on the individual. There's no [coughs] - excuse me - there's no criteria saying someone who's done this can't get it - actually there might be some but I'm not going to go there.

Must have professional indemnity insurance in place - I don't know of any Aboriginal health practitioner or Aboriginal health worker that's in private practice so most of us are covered by our employer. But some employers we do get questions from employers, not so much the government sector but non-government sector where organisations have to pay indemnity insurance for their professionals working for them, their staff and everything else.

If returning to practice, not to have been absent from the field for a long period of time so there's set timeframes in the study hours. You can return to work after a long time but you might be asked to do clinical assessment or something like that depending on that time period and how long ago it was and there's guidelines around that if it's been three years, five years, 10 years, that sort of timeframe. It's best to actually have a look on the website, have a look at those standards.

There is also a very good frequently asked questions paper that's on that website as well.

Registrants' responsibilities - so renew and pay registration each year by 30 November.

Undertake a minimum of 10 hours CPD per year and a minimum of 60 hours over three years or at least four to five hours as formal CPD activity, i.e. courses, conferences, seminars, in-service, et cetera. What we didn't want with the 60 hours is someone going along to a conference for 60 hours and saying I've done it. We want people to have a diversity of in-servicing so they can actually go and do some clinical training. We don't actually count the first aid in that time period because we think it's mandatory to have that anyway, so we don't count the first aid certificate as being part of CPD, just as a little add in there.

Comply with the Board's code of conduct - every health professional's got a code of conduct. Most of ours is pretty much the same as all the other registered practitioners.

The Board has come a long way. We were appointed in June 2011 to prepare for national registration to start one year later. It was a real scramble I can tell you because we started and then we had to sit down and write all the standards and guidelines and look at the direction we wanted to take.

At the time we registered 171 practitioners, this is when it changed over. Two hundred and fifty three from NT and 80 from others and as of 1 November 2013 there are 322 and you'll notice the registered practitioners but we have lost some since then as well because you get natural attrition, we've had some pass away unfortunately so the number's back down to about 308.

What's happened too over the time is that there were a lot of people who - a lot of practitioners who just reregistered every - they were mainly from NT that reregistered every year but they never went out and practised but then when they had to prove that they had CPD and all the rest of it, I think it became too much so they just didn't reregister.

Our registration function in place and last month we approved a new accreditation standard. I've already mentioned that. Despite limited funds we prioritised being here to discuss the registration with you.

I'll talk a little bit about the Board itself. There's 14 boards already, there's the dental, medical, nursing, the whole range of them. There's nine members on our Board here and our members are here today. We've got - maybe Clare put your hand up. Clare Anderson who's a public member. Jenny Poelina's Queensland - WA sorry - WA - she'll kill me later - Western Australian practitioner. Bruce you've met, he's a Queensland practitioner member. Sharon Milera is a South Australian member. Who have we got over here - Renee Owen's a Victorian practitioner member. Lisa Penrith

Female: [Inaudible - no microphone]

Peter Pangquee: New South Wales. She just got married [laughs]. Where's Jane? Jane's at the back of the room - is our public member from [unclear] New South Wales and Karrina DeMasi who's our public member who's not with us today. Gilbert Hennequin he is our executive officer. Gilbert does all the legwork for us.

All board members are appointed by Health Ministers and if you had your ears to the ground just recently they called for new members to the Board. Our term finishes in June this year, 30 June, so we've all had to reapply, so that process is happening now so that the Ministerial Council can appoint a new Board.

All boards are self-funding through registration accreditation fees that are collected. We're a little bit of an exception because we've got a grant to start and if we try to survive on what we collect we wouldn't be here today unless we charged every health practitioner a couple of thousand dollars each, which I know I can't afford.

So we do have a small grant and we've been living on that grant since we started. I think we've got another year out of it, then we'll have to start begging to the government, but anyway we're hoping that they'll be supportive of us but we need to get the numbers up so make it worthwhile and use this profession. As I said there too, it's not guaranteed.

The Board and AHPRA - a national law established the 14 boards with the responsibility to be regulated by - sorry to regulate the 14 professions under NRAS. NRAS is the National Registration Accreditation Scheme. AHPRA is the national agency that provided administrative assistance and support to the boards and exercising their function in an efficient and effective manner in accordance with the regulatory practice.

We've got a couple of people - Jill who's sitting on this table here, actually is the Northern Territory Manager and the registration of practitioners is done through that office. They're collected nationally and sent to that office, then it comes to the Board - oh Matt and Matt's the Queensland State Manager. Sorry Matt [laughs].

Yeah so AHPRA is contracted by - or AHPRA is funded by the boards. We pay so much to AHPRA to perform those administrative functions for us. We also delegate some things to AHPRA too.

Like if a practitioner applies for registration, there's no criminal history, they've got the right qualification, everything else fits with the standards and the guidelines, we give AHPRA permission to register them on our behalf but their names still come to the Board when we have our board meetings and registration meetings. So it just cuts down on some of the work that the Board has to do. If you imagine some of the - like the Medical Board and Nursing Board or nursing especially with 330,000 registered practitioners, for the board to read every application they'd be there forever.

So they're on contract, they employ staff and implement decisions on behalf of the Board. There's an AHPRA office in every state and territory and for more information contact Gilbert but you can ask me some questions now too if you like [laughs].

That website has got the codes, the standards and guidelines and any news. After every board meeting we send out a communiqué on some of the basic things that we do, decisions we've made and that gets sent out widely. So if you don't get it maybe go onto the website and have a look, it'll be there.

Have I forgotten anything? So I'm happy to answer any questions. Yep?

Female: It's Deanne Minniecon from Diabetes Queensland. Just a quick question around the continuing professional development and in terms of the 4.1 formal learning, how does an organisation I guess acknowledge what is formal learning? Is there a process that goes through you guys to say well yeah this one is the formal learning and this isn't the formal learning? Is there an accreditation for the training I suppose?

Peter Pangquee: There isn't one but we're actually working on that and that's a question actually we spoke with - we're going to if we haven't already with the Aboriginal Health Workers Association because you know how sometimes people have conferences and they'll say this is worth so many points for different professions? We haven't got to that point yet but we'd like to, but most conferences do have that and I guess what we'd probably do is acknowledge if another profession's already said they'll acknowledge it then we would do the same.

Female: Is that currently happening now?

Peter Pangquee: Yeah if you're registered and you've been along to a conference or have been along to a course then I'd document that in your portfolio. We don't check every practitioner every time they reregister, it's through an audit process, so we might do 20 per cent, 30 per cent, of practitioners. I don't know if there's any registered practitioners in the room but recently there was an audit on criminal history so what they'll do is they'll randomly pick out 30 per cent or 40 per cent of registrants and then they'll run a check on it. So we do it in that sort of process yeah.

Female: Thank you.

Peter Pangquee: I got audited by the way [laughs] so I'm not immune. Pretty quiet out there.

One of the questions that came up in other - I'll put myself on the spot now - is the scope of practice and there's actually some work being done now between the Health Workers Association, Health Workforce Australia and the Board. We're actually having some discussions about that very thing at the moment. What is the scope of practice of Aboriginal health practitioners?

I know there's a lot of people who probably want to ask that question, but one thing we have to be very careful of too when you come to scopes of practice is quite often if you put a scope of practice out there and you put a boundary around what happens and health practitioners can do, people won't let you do anything else.

So there's a danger in that too and what we used to say in the Territory was - you know, people used to ask what can an Aboriginal health worker do - this is prior to national registration - and our answer was they can do whatever they're trained to do as long as it's within the guidelines and policy and everything else, best practice. As long as it's within that framework of their organisation, where they work, then they can do whatever they're trained to do.

We do have health workers who are doing dialysis. We have health workers who are now working in palliative care. We have health workers in diabetes. We've got one in the diabetes area now in the hospital in the Territory. She works with the people in the hyperbaric chamber so she's qualified in that area as well. We've got female health workers who are doing scans, doing ultrasounds. They're trained to do that in their - they're trained in say Alice Springs Hospital and they do it in their community and those results are sent into the doctors to analyse.

So yeah we are yet to have that big discussion about the scope of practice around clinical especially.

Female: My name is Debbie. I'm from the Royal Brisbane Hospital. One of my questions is identifying the role of an indigenous health liaison officer is completely different to a health worker and that's something we're looking at changing above board with Queensland Health. I'm just wondering if there's anything out there, and also just with the position descriptions, is there anything that is written to say what the actual health worker's role is under AHPRA of course?

Peter Pangquee: Yeah. AHPRA wouldn't do that. I mean our main role is to register practitioners so we don't get into writing job descriptions and what people can and can't do.

Female: It's just one of the questions that the indigenous health workers where I work with we have that problem with people telling us what to do and we want to write another position description that's more advantageous to us as health workers. I don't know what other people's thoughts are on it but I just thought I'd put it out there.

Peter Pangquee: Yeah I think probably the way to do it is through those job descriptions and having very descriptive job descriptions and duties that need to happen.

It is - I always find the problem is it's not the health worker, they know what their job is, it's the people around them to know what their job is.

Female: Exactly.

Peter Pangquee: That's a really difficult one. We find even in our remote health centres because you have staff changeover you'll have - I'm not picking on nurses but generally they're the ones who come and go in the community and often from down south come out of a hospital and they'll go and work in a remote community and they're always questioning what the health practitioner is doing. Often they go oh no you can't do that. Excuse me I've been doing it for the last 20 years.

So it's often about having good orientation, really good information out there and we tried to do that recently with the Rural Health Development Education Foundation yeah who unfortunately has just closed. They weren't funded again but they were out there. We used them. Actually there's a DVD going around with a panel discussion and that's been on NITV channel 34 on and off for over the last year now I think. You'll even see Bruce on there at his Wuchopperen doing his job as a health worker there, health practitioner, but I think it's more around that as well to try and promote the profession and to ensure that other people know what we do.

Just a little example of what happens in the NT, our *Poisons Act* is a little bit different to elsewhere because Aboriginal health practitioners are mentioned in the *Poisons Act* in PADDA and what happens is the chief medical officer issues a gazettal notice and in that gazettal notice he'll actually state what medication an Aboriginal health practitioner can give, how it's given and in what locations. So all of our remote health centres, all of our ones in the city like Danila Dilba, Clinic 34 which is SDI type clinic in Darwin. You've got health workers in there that can - anyway what they do is they have a list of medication, how it's given and that's adhered to and most of those medications that are listed in there are in another document that our Aboriginal health practitioners use and that's a CARPER manual in the Northern Territory for remote practice.

So all the medications that are mentioned in CARPER is also in that gazettal list, so all the immunisations that you would expect to give children, childhood things, is listed in there as well. We've got a bit of a run on measles at the moment in the Territory. I think there's 38 cases been notified already and growing I believe, but they've issued notices around all our health practitioners that opportunistic immunisation is always available.

But our Aboriginal health practitioners are able to do that as well, so it actually enables a broader range of people giving medication in one instance.

Female: [Inaudible - no microphone].

Peter Pangquee: I knew that'd raise some - I knew it'd raise some questions [laughs].

Female: Karen Mounsey from Apunipima Cape York Health Council. Just wondering what the Board's role is just bringing up the medicines and the different acts across the different states and territories and seeing that as a limitation to bring the health practitioners on an equal basis with their colleagues, the other regional health professionals. So is there anything happening at a national level in that space and also I'd say at a state level to influence that change to enable people to be able to get that particularly in a remote area? I know that's a challenge for us because we're limited by it.

Peter Pangquee: Yeah. I don't know the exact wording but in the health practitioner - the act that we're registered under there is also a section in there that talks about the workforce and I guess I've always wanted to use that section to help promote that and we've had lots of discussions with Health Workforce Australia about harmonising the *Poisons Act* across Australia.

So we've been involved with those and we're, I guess one of the key stakeholders. Whilst it's not our responsibility as such, we - whilst it's not our responsibility as our first priority, we do get involved with that workforce. I think coming here and talking here now about it, I think promoting the workforce, our profession, I believe it's part of our role.

Female: Yes [inaudible - no microphone].

Peter Pangquee: Yeah. I also sit on the board chairs forum and the board chairs meet four or five times a year, you know, teleconferences and two face-to-face a year and at those forums I often have that discussion with the other professions about where we stand. I think it's great that we sit at the table with the other professions.

I think what we've got to do more about is we have to do it more in the workplace I think and at the grassroots level because without the other professions' support we can't grow. There's always a discussion about growing your own so we need your help, the other professions out there, to help us grow.

If you do look at our profession going back once again in the NT, we wouldn't be here today if - in the Territory we wouldn't be there today without the doctors that used to work in the Territory and they were the ones who used to do all the training on the ground and in the community because they saw a need there. They'd come into the community once or twice a month and go home, then they'd get a phone call and say oh the baby's really sick and you'd say well what's wrong with it, oh I don't know it's really sick. All they wanted was someone on the ground with some training to actually do the obs., check it out, give it fluids, give it Panadol, give it whatever.

So without those doctors actually training people on the ground to do those basic things in the early days, we wouldn't be here today I think. So the medical profession were great instigators in the early days for our profession in the Territory.

Female: Thanks Peter, it's Amanda Hammer from the Department of Health. I just thought I might make a quick comment about the drugs and poisons authorisation and raise awareness about potential opportunities to influence the state-based legislation in that regard. Then I might just make a quick comment around the clinical governance around the Aboriginal and Torres Strait Islander health practitioner role particularly within the public healthcare system because we have done some work to provide some guidelines to promote utilisation of the role within our HHSs.

Firstly in regards to drugs and poisons, I think everyone in the room knows that the decision around drugs and poisons authorisations is a state and territory based responsibility and health ministers were very clear on that in the policy development for the National Registration and Accreditation Scheme that states and territories wanted to retain that decision-making. So whilst national boards can certainly set the broader parameters about what the profession is skilled and competent to be able to do in that regard, again at the end of the day the decision is up to the state or territory.

The anomalies across borders is apparent across a range of professions not just for the health practitioner professions, so you'll have some other professions having different levels of authorisation across the board.

But where we're at, at the moment. I've been advised by the department that there will be an opportunity from about middle of this year, there will be a consultation process around a rewrite of our drugs and poisons regulation that is coming into play. There's also a major review going on regarding the overarching *Health Act* that sits above all the regulations including drugs and poisons, and there will be an opportunity through that consultation process to provide a strong argument in regards to the authorisations potentially for this particular profession.

I've had some discussions about the level of evidence that would be required to support that argument, and my colleague and I, Rebecca here, we were fortunate to be up in Cairns a little while ago and meeting with the HHSs and people from the community controlled sector. We started having some discussions about what we can be doing in advance to try and get that evidence together.

So there is a window of opportunity, it is going to be a state-based decision, so whilst although there is some work going across to look at nationally consistent drugs and poisons authorisations across all the professions, at the end of the day we need to be looking to the state government.

Peter Pangquee: Yep.

Female: Just quickly, from a department's point of view - and I will refer people and we can provide perhaps by email to participants where they can source some materials that are being developed by the department, but we're very keen to establish a national - sorry a state-wide consistent framework to support the utilisation of the health practitioner role within our hospital and health services.

To that end through a consultation process we actually published in the middle of last year clinical governance guideline with supporting tools and templates and have actually done things such as a draft job description and some guidelines around employment arrangements, but there's a lot of work to be done at that end as well.

But we've certainly - it includes a lot of material around supervision, CPD, practice plan - proposing a practice plan which would be agreed between the health practitioner and their supervisor which would be supporting the argument about have a clear document that describes what that health practitioner is able to do and can be used as a communication tool with other staff.

So I'll finish there, thanks for the air time, but happy to answer questions afterwards.

Peter Pangquee: Sounds like great news ahead with the right influences [laughs].

Female: Hi my name's Peggy. I'm from Inala Indigenous Health and I was just wondering about these roles. Is it true to say that even though people can get registered those qualifications won't necessarily be recognised in the position that they're currently doing as a health worker because they're not health practitioner roles, as in the qualification it's like say you're a registered nurse and you were sitting in a health worker role, your nursing qualifications wouldn't be recognised?

Until those roles are changed to health practitioner roles that qualification won't be recognised. I just wanted to be clear that that's correct what I'm saying.

Peter Pangquee: The qualification enables a person to be registered, the appropriate qualification that's at Cert. IV practice. That enables them to be registered, but when it comes to the work on the ground that's an employer responsibility. We can't tell them what they have to do with them and what they can and can't do.

Female: So what I mean is that the health service, the HHS - like I'm in Metro-South so Metro-South would have to implement health worker roles, health professional - I mean health practitioner roles and those health workers would either have to get their job description changed to that role or apply for that role before the qualification is recognised.

Say they're changed to a different stream, health practitioners might be in a different stream than the current career structure. Most health workers now come under a 00 stream. Health practitioners hopefully won't be in that stream and they can't just automatically because they've registered go into the health practitioner stream and stay in the same job doing the same job description that they're currently doing.

Peter Pangquee: Yeah well look I think most jurisdictions are in a similar sort of role - a similar place at the moment. They've got Aboriginal health worker positions but they're not Aboriginal health practitioner positions. So what employers and that would need to do was look at what roles they want people to play, but also looking at what job they're actually doing now.

I know in one place there the child health workers are actually doing some clinical practice and the employer should really seriously look at what they do, and in my view if they're doing something that's - well something that endangers the public like doing a clinical practice that endangers that person, then they should consider having a registered practitioner rather than just an Aboriginal health worker or a community worker doing it you know.

Female: Yeah. So it's down to the HHS really how they implement these roles I guess yeah.

Peter Pangquee: Yeah it is up to the health service and employers yeah, but I'd be encouraging people to look at what those roles are and if there's a danger to the public in that role then maybe they should consider changing that position to a health practitioner position and have them registered. At least then you know that the person going into that position has got a minimum standard of clinical training and that you know that they can do this level of work. It may not be at the top of the range but they know what the base grade level is.

I think that's the thing about registration; we're hoping it's going to be a guarantee that once you're registered you become registered. You know that you're at this level and everybody's at that level. It sets a benchmark and it sets a benchmark for minimum standards not the top.

Female: Just on that, I've been working in Aboriginal health for 40 years now as an Aboriginal health worker since the mid-'80s. I think what people are getting stuck on is two words: worker, practitioner. A Cert. IV Aboriginal health worker has the same qualifications as a registered Aboriginal and Torres Strait Islander health practitioner, it's the same qualification. This is what I don't understand what employers are getting stuck on because they're doing the same jobs and like Pete said, if you're registered then it's a regulation and then the public knows that you've actually ticked it all off properly.

So I just don't - as a health worker I can't understand why everybody's getting so stuck. It's two words. It's the same qualification. People need to get registered so that they come under - the public can see that they've got guidelines and standards.

Male: Good morning bros, Ash Currie here from Metro-South. I was just looking at some of the words that sister said and most of my questions have been answered so far, but I think it's probably the process we need to follow in how do we support staff to make sure that they have every possibility of applying for registration because with this element of change that we've all been through, there's been a lot of disruption.

I think a lot of us saw a good opportunity to lift ourselves to that par, knowing that a lot of staff members that we have in our areas have been doing those roles for long periods of time and they see that light at the end of the tunnel saying great I can apply for this now. Where at the moment I see it's a disadvantage where some of the districts may say no we can't support that position doing it now.

So they've been supporting for the last few years and it's okay for our staff members to do that job, but we need to make sure that we give them every opportunity and an advantage to apply and I believe it's the district's responsibility to ensure that all of our staff members firstly, have the right qualification and secondly, are supported in their applications to ensure that Aboriginal and Torres Strait Islander health are lifted to a standard where we are at the same par as every other professional.

Peter Pangquee: Yeah good comments yeah. We're in a...

Male: Can I say something?

Peter Pangquee: Yeah.

Male: I've had my hand up for a while and it's getting sore.

[Laughter]

Male: Sorry sister, I see you there. I remember when we did the training. Remember that Flo when they bought in the accreditation in Queensland and we did the training and I did it with Vanessa and there was a couple of others around the place. We had this thing between it was a community controlled health - Steve Corporal by the way - we had this thing between the community controlled Health Services and the Queensland Health Services that they provide and at the Health Services we had a whole role - you know, like I used to work in the welfare section, did everything, it was sort of lucky-dip. If someone came in and it didn't fit into the medical they would come and see me and it was just anything.

I remember playing guitar at a funeral one day. Drive the bus, do everything, and you're thinking now how does that fit into your job description as an Aboriginal health worker. There's always been this thing between community controlled and the state health worker and sometimes the Queensland Health mob which are the ones here in Queensland they'd put people on and they didn't know what role to give them. The people did the training as well, near 20 years ago, and we have that - I thought we'd moved on a long way from that, but by the sound of it we're still struggling with that, what role do people have.

I'm a counsellor. I actually work at uni these days and people still don't know what I do. We do stuff for our community and where does - anyhow going to my question, where does the counsellors fit into it that are old Aboriginal health workers like myself? I've got the old primary healthcare Cert. IV and I've worked in the welfare section. I've actually - I'm a social worker now and I have three degrees, but I'm just sort of thinking where does the Aboriginal health worker who's a counsellor, works with our people, may work with a men's group, women's group, works out of the health service maybe Queensland Health or the community controlled one? Where do they fit in the picture if they get the qualifications?

Peter Pangquee: Yeah that question's come up quite a bit actually. Yeah that question has come up quite a bit about mental health workers which is a similar sort of I guess question: what do we do about the mental health workers?

There's probably two or three things that can happen, (1) is they could be in an Aboriginal health practitioner stream which means they would have to have that qualification to be registered in the beginning, and then specialise in mental health or in the counselling type roles.

Just for example, we have Aboriginal health practitioners in mental health in the Northern Territory, there's not many, but there's also a group of mental health workers who haven't got the qualification for registration. They're not registered so they're in another stream, they're in the mental health stream and I guess they come into an admin type stream and those positions haven't been changed over, but not all of those mental health workers at the time wanted to actually be registered because they didn't want to go and do the training that's required to be registered.

People might say well why should they, they're not doing that hands on clinical, that type of role, they're doing the counselling type roles, but I think as a profession we need to actually have some boundaries around what this profession is and what training you need to have to be in the profession because our role is to make sure that everybody who registers is a safe practitioner and that they can do the job that they're trained to do.

That probably doesn't answer your question directly but it is a difficult one. That question's always been raised and if you go back to when the Aboriginal Health Worker Association was formed a decision had to be made around who is an Aboriginal health worker and that was a big one and Jenny knows that. We were around a table for days, weeks, months, you know, like [unclear]. Warren knows that too because we were on the [unclear] committee that actually helped set it up. You had to define what an Aboriginal health worker was.

There were people out there driving buses being called Aboriginal health workers. To me you're a transport officer you know, you're not an Aboriginal health worker. Aboriginal health worker, that profession is more specific. Then there's mental health workers; that's a profession specific. Aboriginal and Torres Strait Islander health practitioners, registered now. That's a profession on its own.

So we need to start looking at some of the - I know it's putting people into boxes and silos and some people get upset - oh no you're forgetting about us, well we're still part of the system - but no one is saying that if you're not a registered health practitioner no one's saying that Aboriginal health worker jobs out there aren't still there and there's still jobs to be done. There's still work to be done and there's still work for that role, but there's also now a role for an Aboriginal health practitioner.

So it's in that time now where it was a bit like when the Association first started identifying what is a health worker to now what is an Aboriginal health practitioners and what they do. I guess in some ways it's lifting the bar, it's setting a standard, it's growing a profession.

Male: The reason I asked that is I'm just wondering where - we're the social and emotional wellbeing counsellors and they're starting to develop in the community for stolen generations, for different groups including Link-Up and also Noeleen's here. I'll just hand it over to her. She's from a counselling organisation which predominantly has Aboriginal and Torres Strait Islander counsellors.

Peter Pangquee: Yep.

Female: Yeah thank you. I just wanted to be clear about what it is, what qualifications do people need to register with AHPRA. We've been around for over 20 years. We've got people working for us who've got diplomas in counselling, Cert. IVs in mental health, also social workers, that kind of thing. So is AHPRA going to be looking at including the SEWB workers or counsellors or is it just the medical or clinical workers that you're looking at? Just to be clear.

Peter Pangquee: Yeah look I'll tell you what happened, when we set the standards and the guidelines for this profession we agonised over all of that as well and there were lots of arguments in the room I can tell you, but we decided that we would make the profession what it is now, a very specific qualification and that we made a promise to the health ministers that we would actually do some other research and work on that which is what happened.

There was another lot of work done and that was sent out, that bit of work was sent out nationally for consultation, national consultation, and it came back - overwhelmingly came back that we were right to just register this profession as it is and that there would be some other work done around mental health and counselling and all that.

So there has been work done. We promised the minister that we would do that and we did that about 18 months, two years ago. Went out nationally and yeah it came back that we were okay where we were with what we had and that further work would have to be done around that other area.

Female: [Inaudible - no microphone]...looking at setting up a registered body for counsellors, SEWB workers, that sort of thing, or were you thinking...

Peter Pangquee: No the current work that's happening now is because there's been work done on trying to identify other health practitioners or workers that may need to be registered. Now that body of work has already been done through HWA. The only one that came close I think was paramedics. I could wrong but I think paramedics was the only one that came back very strongly recommended that they should be registered. The others would be looked after in another way.

At the moment there's another project that's going on to look at unregulated or - the term is unregistered health workers but nobody likes the term unregistered health workers so it's just other category of health workers that should come under some sort of code of conduct or code of conduct and ethic...

Female: [Inaudible - no microphone].

Peter Pangquee: Yeah sort of a self-regulating model but there is work out there now and I think there's through Health Workforce Australia and Health Workforce Principal Committee are doing some work on that now and actually my other hat on when I'm back home. I've got to actually do a response to one of them. But it's about exactly what you're saying: what do we do about other professions that maybe could harm the public like through counselling and other things.

But it also may be worthwhile looking at if it's under that counselling category and there's mental health workers, social work. There's always opportunities I guess to approach other associations to be part of their body and that bit of work could always be done, it's not impossible.

Male: Just last one. This is the last one I promise.

[Laughter]

Male: I was just thinking about my sister Deb there. When you're working in a hospital and you're - or for Queensland Health - not to pick on Queensland Health - but just saying you're there, you're an Aboriginal health worker working there and someone just sees you walking around talking to all the Aboriginal and Torres Strait Islander people at the hospital and they go oh what do you do, just have cups of tea all day and that.

I've had that said to me when I've gone to the hospital to visit people years ago and you're thinking don't you know you fool, I'm here supporting my people in this hospital and connecting them with their family and so forth. So how do you - like it's not a clinical model...

Peter Pangquee: No.

Male: ...it's a caring model so where does that fit in? Do they come and get registered as an Aboriginal health worker and then people say well how much clinic time have you had and they say well I don't do that?

Peter Pangquee: Yeah I think it goes back to the discussion we had earlier about the role of Aboriginal health practitioner and that often it's not the practitioner themselves, they know what they're doing, you know what you're doing, but it's the people around them who don't know what they're doing. So sometimes it's about your work colleagues and the system letting other people know what you do and how you do it.

So it's more around I guess good orientation with staff coming in, knowing what your roles are through staff development training, all sorts of ways of doing it. Unfortunately it's not our job [laughs]. We're very tight in what we do, we've got legislation where we have to do things, but I like the discussion about where we fit you know.

Female: [Inaudible - no microphone]...and things like that being culturally supportive. So I think that's what the people are trying to get at. Is there something that you guys could maybe put in place so that way it comes from the top of you guys in a board level down to us health workers, practitioners?

Peter Pangquee: Yeah, unfortunately we can't tackle that. We can talk - we sit at the table with other professions and other groups, workforce groups, and that's talked about often, but I mean other places could be like the Association, if you're a member of the Association, to talk to them about it.

We've got to be careful too because the Association if it's an industrial issue it's not the Association's job to do that either, it's unions who do that sort of work. So we've got to work out what the issue is but I'd talk to the Association in the first instance you know.

Female: Also just coming from a health perspective, we don't actually as health workers, practitioners - we meet with other indigenous health workers but we don't actually have anybody supporting us that we can go to and that's where we're finding what some of the issues around with Queensland Health because we can go above and beyond people but we don't want to do that but we need more health representatives in health and out in the community as a team leader to say this is someone we can come to and discuss issues with as well.

I don't know if other health workers have that but that's what we're finding. We're segregated from everybody else and we just don't have anybody to go to.

Peter Pangquee: I'm sure there are some senior Queensland health people here who are hearing you now.

[Laughter]

Female: That's not disrespecting hierarchy or anything in general, it's just the point that all us health workers when we meet together we have this like who do we go for discussion without stepping on people's toes.

Peter Pangquee: Yeah I understand. Okay we might...

Female: Can I just ask a question. Jocelyn from Cape York. I have health workers currently that hold their [unclear] and from what I gather from the meeting last week [unclear] we went to the job descriptions for a 004 level [unclear] health practitioner 004 whereas to get to IPA you needed your diploma. So why would you become registered to be 004 person when you currently could get a 005, 006 wage? Why would you become registered? It doesn't change any practice that I'm doing now.

Peter Pangquee: Yeah I understand.

Female: I'm finished now.

[Laughter]

Female: So why would someone from the Cape become registered if they're going to get a lesser wage to be a practitioner? That's my question.

Peter Pangquee: Yes sorry I'm not aware what your Aboriginal health practitioner structure is.

Female: We don't have an Aboriginal health practitioner structure at the moment, we have health workers and we have health workers with IPA (Authorised Isolated Practice), and you need your diploma in primary healthcare to gain that qualification. We went to the GNARTN (the Greater Northern Australia Regional Training Network) meeting last week and the job description's for a 004 health practitioner.

Peter Pangquee: Yeah.

Female: Cert. IV.

Peter Pangquee: I can't answer that one actually, I don't know the structure well enough to...

Female: But what I'm saying is why become registered if I'm going to get less money than what I'm receiving now and be on the same cleaner's wage as what I'm getting now.

Peter Pangquee: Yeah. Registration...

Female: Shouldn't change your wage if you're registered.

Female: Yeah but you'd have to change it to health practitioner which...

[Inaudible - no microphone]

Female: It's about safe practice. If you've got a diploma qualification...

Female: Yeah it's about safer practice but I'm providing safer practice. I'm providing safe practice now because I work with nurses and doctors.

Peter Pangquee: But who says you have to be a 004 if you're registered?

Female: No that's the role description that - no like I say to the health workers up there if you want to go and get registered by all means go and get registered, but you can't practice with medication.

Peter Pangquee: No. No well that's...

Female: That's our biggest problem and they want to do it.

Peter Pangquee: Yeah that's an employer situation where...

Female: It's the legislation.

Peter Pangquee: Yeah well I think Amanda talked about that earlier about what they were going to do with that.

Female: Yeah. So my concern is for them up there and that's what they're saying to me and I'm the manager of health worker services. Why go and get registered Jocelyn I'm still practising without it.

Peter Pangquee: I guess when they do bring it in you're all ready for it [laughs].

We're going to have to...

[Aside discussion]

Female: Hi Peter. My question is regards to I guess I'm with Metro-North Medicare Local and my role there is workforce development and a big thing that I'm wanting to work towards is actually get the accreditation process for a lot of unregistered workers that are out there and one of the barriers that we're finding is that there's no RTOs in Queensland that are accredited to provide the search to be AHPRA accredited.

So is there discussions around whether or not you'll find one RTO or have RTOs in Queensland that maybe able to provide that accreditation?

Peter Pangquee: All - I'm told there's three RTOs here - but all Aboriginal and Torres Strait Islander primary healthcare Cert. IV practice qualifications are recognised across Australia. Anyone who's got an Aboriginal and Torres Strait Islander primary healthcare qualification issued since that qualification came out - now it's just changed sort of being updated - but anyone with that qualification can apply for registration as long as they meet all the other standards along with it.

Female: So that's through the grandparenting provisions?

Peter Pangquee: No, no, the qualification is the standard.

Female: Okay.

Peter Pangquee: What you might get is a notation on there to say that the qualification gained - I forget their exact wording - but it's around the medication unit and it's just to alert - it's only a notation saying that this qualification was gained by a non-accredited - through a non-accredited RTO. It only refers to the medicines unit but a lot of RTOs weren't training to the right level. They were doing it in theory - the whole lot of it was fine in theory, but where it fell down was around the practice area, like not practising on real human beings. So that was some of the [laughs] - real human beings yeah. Real people, not dummies you know...

[Laughter]

Peter Pangquee: ...oranges and those sorts of things.

Male: Hey bros I just wanted to ask what's the general feeling with Queensland Health Workforce and how have they been in touch with you especially like through the districts because us as Aboriginal workers usually get asked what's all this about and I sort of said well if you guys are workforce management you should know. So I'm just wondering what sort of feedback you get off Queensland Health Workforce in the new health service districts.

Peter Pangquee: Well no direct contact unless we go out and make contact ourselves, but this forum is I guess the way of doing it to make sure that everybody gets the same information at the same time.

All of our information is all on our website, you know, all our meetings, all the papers are there, some of the communiqués are there so any of the workforce stuff, but also not the Board directly but my other hat I wear I sit on ATSIHWWG (the Aboriginal and Torres Strait Islander Health Workforce Working Group) as the NT representative. We also get a whole lot of work through that area, so Health Workforce Principal Committee. So it's not directly with the Board but I bring that information with me because I do

other work there and people like Amanda and Warren in the past have been working closely and Bronwyn Nardi from here.

Bronwyn's been up to the Territory with the GNARTN (the Greater Northern Australia Regional Training Network) and that's talking about the workforce in education and training in the Top End and across to Western Australia. So we do have contact but not necessarily as the Board itself. We run these workshops on these forums like this now so that we can share information and answer the questions that people have got out there and try and I guess get people to register [laughs], but also letting people know what we're about because there's a lot of misconceptions about what registration is.

Male: [Inaudible - no microphone].

Peter Pangquee: I'll go back to that other - any questions from anybody who - not here today but any other time can always contact Gilbert and speak to him about the stuff. So that's the information up there.

Have a look on - sorry with you in a sec - have a look on the website too. There's frequently answered questions paper - frequently asked questions paper and there's a whole lot of information in that.

Female: Just one question. You said that there are three RTOs in Queensland providing Cert. IV in primary health, is that right?

Female: There's two Queensland providers - there's two TAFE ones, one in Cairns and there's another one in Queensland, I think it is and I can't think of the other one - Toowoomba.

Female: Okay so three TAFE?

Female: Two TAFE.

Peter Pangquee: Two TAFE.

Female: Those two TAFE centres have actually got the new qualifications on scope and just [inaudible - no microphone]. The RTO actually has to employ Aboriginal and Torres Strait Islander primary health care expert and that's where if you're Aboriginal health worker or whether they're recognised as such by their community. So it can't just be the CEO, it needs to be somebody who has got expertise in Aboriginal primary health care and they are required to do the assessments on behalf of the units, but they have to have those types of employees in their [unclear]. It's very, very strict, very strict.

Because the government allowed the Board to say that we need some Aboriginal and Torres Strait Islanders, it's also now allowed a training package to say that only Aboriginal and Torres Strait Islander people get enrolled to do that course.

So, it's given us lots of strength as we're going along the way.

Male: Hi I'm Wally Anderson from Ipswich. Well my understanding when we first started this journey was that we were doing a baseline for Aboriginal and Torres Strait Islander health workers, just like nurses and doctors or nurses you might say, and again I don't like to pick on them, where they had a baseline for nurses' registration.

I thought we were going to do that, get a baseline registration for all us Aboriginal health workers, have an agreement between the minister and your jobs or whatever kind of work you're doing to continue to do that, to continue to get paid for that, but register us so that we as an organisation or a health body have a say, have power to say that what we're doing is recognised legally and that we'd move forward from there. Then once we'd got that done was to then specialise or work on those areas in those specialised areas like I'd say counselling or any other kind of specialised area or is that wrong?

Peter Pangquee: I thought that's what we did, we did set the qualification.

Male: But now you're saying that people that are in counselling can't get registered so it's either yes or it's no. So are we going to get everybody registered and then work on that or are you saying no we won't

register certain people who have counselling qualifications or mental health qualifications because once that baseline's set then we can look at those specialised areas.

Peter Pangquee: Yeah. Well the baseline has been set at the Aboriginal and Torres Strait Islander primary healthcare...

Male: I know but you can't be saying that then we can't register you now because you're specialising in mental health. We should be saying well you register but we're not going to say that you can't do mental health because you do do that with your job.

Peter Pangquee: Well basically you're correct we can't register you unless you have the standards that are outlined by the Board...

Male: Yeah I understand that so they have that standard, but you can't - because you just said before that mental health people that work in - you know, mental health workers can't register because they're not in a clinical practice, but...

Peter Pangquee: No if you went out and got the Certificate IV Aboriginal and Torres Strait Islander primary healthcare practice and you don't have a criminal history and all the other guidelines that are there so your standards, then we will register you, but that doesn't mean that your employer's going to employ you as a health practitioner. That's where you're probably...

Male: Well that's what I'm saying. That baseline should be able to - for everybody to register.

Peter Pangquee: Well it is, it is, you can register. If you've got the qualification you can register, the Cert. IV practice.

Male: I understand that but what I'm saying is then I don't think it's good to say well because you're mental health worker you can't register or because you're counselling you can't register. I think because it's a basic health worker role you can register but again you do in your area.

Well Florence wants to say something, okay.

Peter Pangquee: See that's like being a member of the Aboriginal Health Workers Association. You've got to have that Certificate III in primary healthcare.

Male: [Inaudible - no microphone].

Female: Wally can I...Can you all hear me without the microphone?

Peter Pangquee: No.

Female: I'm Florence Williams - don't turn around Warren please [laughs]. I'm with the Greater Metro-South Brisbane Medicare Local and I've been in Aboriginal health for 40 years and - do you want this even higher - I started my career with [unclear] Brisbane here as a dental nurse and I became a CEO of a community controlled health service and then I did 18 months with Queensland Health in workforce development and then I worked for the Workforce Council here in Brisbane for five years and now I'm with the Medicare Local. So that's my little journey in Aboriginal health.

I was involved in the purple book before it even became the yellow book under QAIHC as the chair of QAIHC back in the '90s and there were lots of discussions and what I'm hearing now is what was discussed years ago. Sister over there was saying people are getting caught up with words about I'm a health worker, I'm a health practitioner.

I was involved in QATSIHWEPAC in Cairns from the '90s and I was part of the established of ATSICHET, the other training body here in Brisbane that delivered the primary healthcare qualifications.

What Steve was saying that when the qualification was first developed in partnership with the TAFE in Cairns with QATSIHWEPAC and it had an AWEP program sitting at the TAFE to deliver, it was all around clinical and it was about the health workers working in the Cape and the Torres being limited access to nurses and doctors that they were doing a lot of clinical procedures up there and needed that

clinical training. So from Townsville up that's where they took their intake from in the '90s to deliver that qualification.

There was a beginning level at Certificate IV in primary healthcare and it had a clinical component. Then when the government turned out to break the unemployment cycle and all these traineeships came about, that was when the Cert. III came in. That Cert. III was never an employment benchmark, it was a traineeship, but as time went on Cert. III became the minimal standard to be employed as an Aboriginal and Torres Strait Islander health worker here in Queensland. I'm only talking Queensland so if there's any fellows out in this room that are from another state don't go no, no, no she's got it all wrong because I'm talking about our state.

So then when I finished at the community controlled sector and went across to Queensland Health and was their central zone workforce development officer, we went through a whole process there about implementing their indigenous workforce management strategy and that's what us workforce development officers were involved in.

There was a lot of work around the scope of practice and Queensland Health's career path to fit into what we're all yarning about here today about a recognised professional workforce. Lots of consultation happened and there was an audit done on Queensland health workers as well as the AMS workers because in the Queensland health sector they weren't doing clinical so when the national training packages came out two qualifications were packaged: a primary healthcare practice which had the clinical component and a primary healthcare community which was non-clinical.

So there was a lot of health workers out there entering the workforce doing the community and not the clinical because they weren't required to have a clinical component or to do a clinical role within their job.

So when this registration stuff - and I'm sorry I'm taking a lot of time and I'm going from 40 years of walking through this journey - the order had to be done because people wanted to be recognised as these health professionals or health practitioners. There was money rolled out through the commonwealth to the state to provide that skill-gap training for those workers to register, but it didn't change the role or the level you were employed at in your workplace right.

If you were employed as a 003 health worker but went and got the qualification, a Cert. IV clinical or practice, to enable you to be registered it was to be part of that registration and to recognise as a workforce profession but back here you're a 003 in community health, you're a 003 in drug and alcohol, you're a 004 if the qualification under that career structures in Queensland Health states and you can go back and Google it. I'm sure it's still there on the website. Through that scope of practice that Queensland Health did was to outline the qualification against that structure, your job role.

Now I think it goes up to about a 990. Like I've been out of it for five or six, maybe seven years; it used to only go to a 005 and then it went into AO stream because all those diplomas and advanced diplomas - or are they associate diplomas and that now? I've been out of this area for a while to actually know what the registration of the qualification is - aligned what you needed to be, but what they were saying was the managers of health workers need to have a health - need to fit not as an administration stream but as an operational stream. That's why Queensland Health went through and changed the AO levels to 00s.

So sister down there you were talking about having a 004 and having the qualification but to be in a role you needed a diploma, that was through that scoping exercise my girl. Yeah [laughs].

So coming back to some clarification here, the benchmark was a clinical Cert. IV right and if you had that qualification you have the right to register right, but to maintain registration you need to maintain against the guidelines. So if you're working as a mental health worker over here and not doing any clinical or a counselling position over here and not doing any clinical, you've got to go and negotiate with your employer to go and do clinical placements right to maintain your registration, though I'm paid at a 004 counsellor or a whatever.

Now there was talk about - and I don't know whether it is now, Warren you might want to - but to take some of the higher levels to a TO level. So there were discussions around that...

[Aside discussion]

Female: ...so they wiped that and that's gone, but that's what it is. Don't get hung up with the words like sister said over there before. We're all - I'm not a health worker but you're health workers employed in health worker roles, health practitioners is about the registration board right and it has a qualification and a level of standards and regulation requirements to maintain that registration and if you're employed over here doing something else, somehow you need to be negotiable through your employer to access the things you need to do to maintain that.

But when you put your hand up like I'm a pharmacist, technician, dental nurse, come whatever, but now I'm Flo as an Aboriginal and Torres Strait Islander adviser at a thing, so I get paid at this level though my qualifications could be getting paid up here somewhere. I took this job under these duties for this pay and that's what you need do but in the registration, so don't get all caught up in words.

So is that some clarification, I hope I've helped?

[Inaudible - no microphone]

Female: There is a way of cross-crediting in the workforce areas of Queensland Health. That if the HR or your managers understand about cross-crediting and gap training, if you need a higher level qualification you don't have to go and do a full qual., you can be RPL. Some of the units that you're doing and work evidence can be cross-credited across. But it's about your job and what your employer has aligned that qualification for that job role.

I know we all do more. I know we all do singing at funerals and bus driving and counselling or finding referrals but that's what your job is, that's what the career structure sets out, that's what the qualification level - I don't know whether the AMSs are still involved with the HSUA Award. It's clearly defined there.

Female: I'm going home now.

[Laughter]

Peter Pangquee: Thank you for that.

Male: So for me that just clarified it for me. We all do get registered. To maintain a registration then you need to I suppose follow the book and negotiate to do that clinical practice, but so it means that I can register if I'm a mental health worker but to remain [unclear] registration. So that's what I was asking, that - because when you said before that we couldn't register because we were mental health workers - I'm not a mental health worker but just for an example...

Peter Pangquee: But I also said if you had the qualification and you fit the standard you can register.

Male: I know but then, like Florence said, to maintain registration you need to do those qualifications by the book. So then you negotiate with your - what's it called - back at your job...

Peter Pangquee: Yeah.

Male: ...and again it doesn't affect what kind of pay structure you do or what kind of level you're on.

Peter Pangquee: Yep.

[Inaudible - no microphone]

Female: Can I just get a clearer indication of what is it - so you have to have the clinical - sorry, I'll start again - so what qualifications do you need to be able to register?

Peter Pangquee: Certificate IV Aboriginal and Torres Strait Islander primary healthcare practice.

Female: That's it?

Peter Pangquee: There's other standards like criminal history check, Aboriginality...

Female: Yeah that's right because we're a counselling service, we are an RTO, we're an Aboriginal and Torres Strait Islander RTO doing Cert. IV in mental health and diploma of counselling and that's the work that we do.

So I just wanted to be clear whether the Board would be thinking about including counsellors who've got Cert. IV in mental health and above or whether it's just clinical, medical type roles.

Female: [Inaudible - no microphone]...book that you've all got, on page 3 under [unclear] registrations standard it clearly states practice means any role whether remunerated or not in which the registrant uses their skills, knowledge, in their profession. For this purpose this registration standard, practice is not restricted to direct provision of clinical care. You need to read the standards. This is what it's all about, standards.

Female: I'd just like to say if you're employed as a bus driver, simple example, and you go off and get your own Cert. IV and you're a clinical - got the qualification for Cert. IV and you're still a bus driver, they're not going to pay you for having the qualification of a clinical worker. You're still getting paid as a bus driver, so it's the position that you're paid in that you get paid for.

Peter Pangquee: Well we might - that was a very good discussion there and lots of questions came out eventually. We've got morning tea organised for 11 o'clock.

[Inaudible - no microphone]

Peter Pangquee: We've got about five minutes. Jill Huck who's the NT manager but also looks after the registration papers so when people apply it actually goes to Jill's office. So if there's any questions around that particular - around registration itself, the process and what happens there, Jill is happy to answer any of those if you have any burning questions about registration itself.

Female: [Inaudible - no microphone].

Peter Pangquee: So it should be around morning tea so you can come and ask Jill - I think some people worry about different - like the grandparenting, if you have any questions about the grandparenting. It don't mean if you're a grandparent you can get registered [laughs].

So there's a question?

[Inaudible - no microphone]

Peter Pangquee: Who's got the microphone? We've got one last question here.

Female: Just one thing I was thinking of what the lady over here's point was, the advantage of being registered. There's got to be something in it for us because it still goes back to our employee if we're covered, our scope of practice is determined by them. So I'm like the other lady is, if there's a problem in the workforce you've got your unions, you've got your other things, so what advantage is it to us as a health worker to be registered with your organisation? There's got to be something that you've got to protect us other than our - because we've got our scope of work practice in our work description when we apply for the position with Queensland Health. So I was just wondering just to me it's a great idea but I don't know if it's got a long way to go because if it's been going on since 1980 it'd be nice if it could move a little quicker that there was something in it for us as a health worker.

Peter Pangquee: Yeah I guess where it'll be realised is if the employers would build it into their structure and about those work roles and about the clinical practice that Aboriginal health practitioners can take on...

Female: Yeah that needs categorising a little bit more.

Peter Pangquee: It will be - it could be promoted a bit better in that way through the employer groups, but it's about the public too, the public knowing that you as a registered Aboriginal health practitioner you've been trained to a certain standard and that we can trust you...

Female: But that'd be a job that you guys are supposed to go out and promote it to the Queensland Health or to the public because there's still that blank spot that...

Peter Pangquee: Yeah they know all about it.

[Inaudible - no microphone]

Female: ...Queensland Health won't recognise it.

[Inaudible - no microphone]

Peter Pangquee: Sorry I didn't hear you.

[Inaudible - no microphone]

Female: ...We've got it, we need to bloody well sign up, get registered because we've been talking about this for too long. Thirty years now, let's get registered health workers, let's get registered health workers or so help me god if you don't want registration then continue to practice the way you're going. Continue to be undermined because that's what other registered health professionals do - is they undermine non-regulated health professions.

We are not considered a health professional if we are not registered by the standards of other health professionals. That's the difference. We've been singing out for this for too long. I know a lot of people say what's in it for me. Well you know what's in it for me, professional recognition. I don't need extra dollars, I've got professional recognition. I've got in my community and I now have it with my other health colleagues. That's the most important thing.

[Applause]

Peter Pangquee: Yeah very important point - professional recognition.

Female: Can I just say one thing? [Inaudible - no microphone].

Peter Pangquee: Yep, yep, that's right. It's like being an airline pilot. We trust that pilot up the front there don't we because we know he's got the qualifications. He's registered, he's got his licence, he can fly that plane, you trust him. We should have the same feeling about our health professionals, our Aboriginal health professionals. You've got the bit of paper, you're registered, you've got a title, we can trust you, you know. That's setting a standard, the benchmark.

Now well look thank you all for coming today. I hope we were able to answer some of your questions and share some information. You'll stay and have some morning tea with us, we'll all be around. Thank you.